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ABSTRACT

Physicians and rape crisis counselors may play important roles in assisting a rape victim: their beliefs and perceptions about rape may influence their treatment of the victim. Physicians (N=10) and volunteer rape counselors (N=44) completed questionnaires focused on demographic characteristics, their experiences with rape victims, and personal attitudes and beliefs about rape. The two groups were compared on eight dependent variables: causality of rape, consequences of rape, women's responsibility for prevention, relation of sex to rape, deserved punishment of rapists, victim's precipitation of rape, normality of rapists, and power as a motivation for rape. There were no significant differences between the beliefs expressed by the physicians and those expressed by the volunteer counselors. Further analysis of the data revealed a pattern which suggests that as physicians and volunteers experience more personal contacts with rape victims, these professionals may: (1) view the psychological impact of rape as less severe: (2) be less likely to regard the victim as the precipitating cause: and (3) be less likely to perceive sex as a motivation for rape. (NRB)

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Interpreting Rape: Differences Among Professionals and Non-Professional Resources

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Interpreting Rape: Differences Among Professional and Non-Professional Resources

Women who have been raped and who seek help have a high likelihood of contacting medical assistance or rape crisis assistance, and in many cases both. Specifically, physicians who work in emergency rooms, and volunteer rape crisis counselors, are two groups of trained persons who may play important roles in assisting the victim during the time following the rape. Because of the major stress the victim faces and because of the significant emotional turmoil she may experience, the beliefs and perceptions these resources have about rape may influence, either overtly or covertly, their treatment of the victim.

Previous research has suggested that health care teams may have negative views of rape victims (Williams & Williams, 1973) and at least one study suggests that one group of volunteer rape crisis counselors was somewhat more likely to see rape as having more serious consequences for the victim than did a group of physicians (King, Rotter, Calhoun, & Selby, 1978). The main purpose of the present study was to examine the self-reported beliefs and attitudes of physicians and of rape crisis counselors in two general areas: (a) negative perceptions of victims: this would include beliefs about the victim's precipitation of rape, tendency to view the victim as somehow causing the rape and so on, (b) perception of the aftermath of the rape, i.e., beliefs about the psychological and social impact of the rape on the woman.

Method

Subjects

Participants in this study were 10 physicians and 44 volunteer rape counselors from the Atlanta area. An original potential sample of 101

physicians was contacted, and the return of completed rating scales by only 10 physicians represents an abominably low return rate of only 10%. The volunteers were beginning or experienced crisis workers from the Atlanta center.

Materials

In addition to an informed consent form, participants were asked to complete questions about their demographic characteristics and their experience with rape victims. The items about rape were those developed by King, Rotter, Calhoun, and Selby (1978), and Feild's attitudes toward rape questionnaire (1978). Participants also completed an attitude toward women scale, but that data is not included in the present discussion.

A Note on the Low Rate of Physician Response

The low response rate from the physicians may be due in part to their responses to the items on the attitude toward women scale. Several spontaneously mentioned that they found the items extremely stated, and personally offensive. Because of that, they simply chose not to respond to anything. The general institutional response to the research project may also have contributed to a poor response rate by the physicians. The project was held up for a period up to a year by the committee on ethics of research with human participants, on grounds which, given the charge of the committee (to assess the ethical aspects of studies), seemed somewhat unusual. For example, one of the "ethical" questions raised was whether attitude research was a valid area for research, and another "ethical" question was whether an analysis of variance was appropriate (our statistical consultants indicated it was).

Given the prevalence of general negative reactions to the attitudes toward women questions, and the less than supportive institutional atmosphere the low response rate is not entirely surprising. Nevertheless, it is still necessary to regard the present findings with a high level of caution, since they may not be generally representative of most physicians who work with women who have been sexually assaulted.

Results

The items used in the present analysis were combined based on their loadings in the factor analyses conducted by King, et al. (1978), and by Feild (1978). King, et al. reported two factors, one which represented the Perceived Causality of the Rape, and the other which represented the Perceived Consequences of the Rape Assault. Feild (1978) reported eight factors in his scale, but only the six main factors were chosen for inclusion in the present analysis. Factors one through six in Feild's investigation included the following:

Factor I - Items representing the woman's responsibility in preventing rape

Factor II - The relation of sex to rape

Factor III - Items dealing with the deserved punishment of the rapist

Factor IV - Items dealing with the woman's perceived role in causing or precipitating the rape

Factor V - Items dealing with the perceived normality of the rapist

Factor VI - Items dealing with power as a motivation for rape

The individual items on each of the King et al. (1978) and the Feild

(1978) factors were summed, resulting in eight dependent variables, analyzed in a multivariate analysis of variance comparing physicians with volunteers. In addition, comparison of the two groups was made on each of the eight dependent variables. The results indicated that on the two factors from King et al., and on the six factors from Feild (1978) there were no significant differences (all $p>.05$) between the beliefs expressed by the physicians and those expressed by the rape crisis center volunteers.

Because clinical experience and some previous data have suggested that the degree of experience of the counselor may affect the beliefs and attitudes expressed about rape victims, (Rotter & King, Note 1) an additional post hoc correlational analysis was conducted, to determine if the degree of experience with rape victims was related to expressed attitudes toward rape victims.

The sum of the items on each of the eight factors was correlated with the number of rape victims with which the volunteers and the physicians had dealt. Of the eight correlations, none reached traditional levels of significance (i.e., $p<.05$). However, three of the correlations suggested possible trends which may merit further investigation. There was a correlation of $-.25$ ($p<.08$) between degree of experience with rape victims and perceived severity of the aftermath of rape for the victim, there was a correlation of .24 ($p<.09$) experience with rape victims and Feild's second factor (Sex as Motivation for Rape), and there was a correlation of .24 ($p<.09$) between experience with rape and Feild's factor four (Perceived Victim Precipitation of Rape). While it is clear that these results are tenuous at best, the pattern suggests the following hypothesis for further testing: that as professionals and volunteers have more personal experience in serving more rape

victims, they may reduce their estimates of the severity of the psychological impact of rape, they will be somewhat less likely to see the victim as a precipitating cause in rape, and they will be somewhat less likely to perceive sex as a motivation for rape. The low reliabilities of the obtained correlations clearly make this a speculation which should be regarded with caution, but one which may provide the basis for further investigation of the attitudes of counselors. For example, King and Webb (1980) have found that follow-up by rape crisis centers with rape victims may frequently not be made; one of the many factors which may produce this lack of follow-up is the decrease in the perceived severity of the impact of rape as counselors obtain more experience in working with rape victims.

Why the absence of any difference between physicians and volunteers when earlier work (King, Rotter, Calhoun, & Selby, 1978), using fewer items, identified several reliable differences between physicians and volunteers? The most compelling explanation is that the group of physicians is a highly self-selected one. One can speculate that these physicians may represent a group of professionals who are concerned and interested in the welfare of rape victims, and that concern and interest lead to their participation in the study, and to their expression of attitudes toward the victim which are more positive than those reported by King, et al. (1978). An explanation that seems less likely, although perhaps more desirable, is that the attitudes of physicians have changed since King, et al. gathered their data in the middle 1970's. The experience with the gathering of data for this study, and the organizational and bureaucratic hurdles which were systematically placed in the way of the researchers (the spokesperson for the research group was a

woman, and hence most of the obstacles were placed in her path by male physicians) suggests that while some changes may have taken place in the attitudes which physicians (still a population comprised predominantly of men) have toward rape victims (predominantly women), beliefs about rape victims are still not as supportive or as positive as is necessary. The small sample of physicians included in this study, however, does appear to represent at least a minority of professional resources whose attitudes toward rape and rape victims are not significantly different from those of women who offer their assistance voluntarily to other women who have been raped.

Reference Notes

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